Intake Form

Name: _____ Date of birth: _____

Address: _____

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____

Cell phone : (_____) _____-_____ Email address: _____

Occupation: _____ Marital Status:_____

Social Security Number: _____ Driver's License Number: _____

Primary care provider: _____ Date of last physical exam: _____

Other doctors or practitioners you have seen in the past year: _____

_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Address: _____

Emergency Contact Phone Number:_____

Height: _____ft. _____ inches Weight: _____ pounds BMI: _____

Highest weight in the last two years: _____ pounds

Lowest weight last two years: _____ pounds

Desired Weight: _____ pounds

HEALTH HISTORY

Are you pregnant? Yes ___ No____ Due Date _____

Personal Medical History:

High cholesterol	yes	no	Arthritis	yes	no
High blood pressure	yes	no	Cancer	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Heart Disease	yes	no	Thyroid disorder	yes	no
Obstructive Sleep Apnea	yes	no	Gout	yes	no
Depression	yes	no	Anxiety	yes	no
Insomnia	yes	no	Kidney Disease	yes	no
Stroke	yes	no	Migraine Headache	yes	no

Other:_____

Please list all previous surgeries:_____

_____

Please list any food intolerances or allergies: _____

Please list any medication intolerances or allergies: _____

AMERICAN COLLEGE OF Lifestyle Medicine

Intake Form *(continued)*

Please list all prescription medications, supplements and over-the-counter medications:

_____

_____

_____

Family Medical History (Parents, Grandparents, Siblings, Children):

High cholesterol	yes	no	Arthritis	yes	no
High blood pressure	yes	no	Cancer	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Heart Disease	yes	no	Thyroid disorder	yes	no
Obstructive Sleep Apnea	yes	no	Gout	yes	no
Depression	yes	no	Anxiety	yes	no
Insomnia	yes	no	Kidney Disease	yes	no
Stroke	yes	no	Migraine Headache	yes	no

Other:_____

Social History:

Do you use tobacco products? Yes No If yes, please describe:_____

How many alcoholic beverages do you drink in a week?:_____

Are you living alone? Yes No

If you don't live alone, who lives with you? _____

Who does the grocery shopping? _____

How often?_____

Who does most of the cooking?_____

If given a recipe would you prefer: (a) someone else cook it? (b) Cook it yourself?

How often do you eat out? _____ Where? _____

Have you made any changes to your diet recently? Yes No

If yes, please explain _____

Is there anything else you feel we should know? _____

_____

_____

_____

AMERICAN COLLEGE OF Lifestyle Medicine